



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KINETIC CLINIC
4151 SOUTHWEST FREEWAY #750
HOUSTON TX 77027

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

19

MFDR Tracking Number

M4-12-0502-01

MFDR Date Received

OCTOBER 17, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken From The Table of Disputed Services: "AUTH
#110405209199...RIGHT KNEE AUTH#110405209199"

Amount in Dispute: \$2,965.00 per *Table of Disputed Services*

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
April 7, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
April 14, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
April 21, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
April 26, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
April 28, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
May 5, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00

May 10, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
May 12, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
May 18, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
May 24, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
May 26, 2011	97140	\$40.00	\$40.00
	97112	\$80.00	\$80.00
	97110	\$120.00	\$120.00
TOTAL		\$2,880.00	\$2,880.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Per the requestor's *Table of Disputed Services* the amount in dispute is \$2,965.00. However, review of the documentation submitted, the division finds that the correct amount in dispute is \$2,880.00.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 10, 2011

- 165 – PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.
- 853– PAYMENT DENIED/LACKING REFERRAL.

Explanation of benefits dated July 15, 2011

- 165 – PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.
- 853– PAYMENT DENIED/LACKING REFERRAL.

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code, Section §134.600(p)(5) requires preauthorization of "physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS)." Review of the submitted preauthorization letter dated April 5, 2011 supports the Physical Therapy

to treat the right knee x 12 Visits was approved under authorization number 110405-209199 with a start date of March 30, 2011 and an end date of May 30, 2011 which includes the disputed dates of service. The requestor has supported their position that the disputed physical therapy services were preauthorized per 28 Texas Administrative Code, Section §134.600; therefore, the requestor is entitled to reimbursement as follows per 28 Texas Administrative Code, Section §134.203.

2. Per 28 Texas Administrative Code, Section §134.203 (c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
 - (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied to \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.
 - (2) The conversion factors listing in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The 2011 DWC Conversion factor is \$54.54.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77027.

3. Per 28 Texas Administrative Code, Section §134.203 (c)(1) the calculations is as follows:

CPT Code 97140-GP x 1 Unit: \$54.54 WC CF/33.9764 Medicare CF x \$27.98 participating amount x 1 Unit = \$44.91. The requestor is seeking \$40.00 x 12 DOS = \$480.00. This amount is recommended.
CPT Code 97112-GP x 2 Units: \$54.54 WC CF/33.9764 Medicare CF x \$31.02 participating amount = \$49.74 x 2 Units = \$99.58. The requestor is seeking \$80.00 x 12 DOS = \$960.00. This amount is recommended.

CPT Code 97110-GP: \$54.54 WC CF/33.9764 Medicare CF x \$29.68 participating amount = \$47.64 x 3 Units = \$142.92. The requestor is seeking \$120.00 x 12 DOS = \$1,440.00. This amount is recommended.

4. The total allowable reimbursement for the services in dispute is \$2,880.00. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$2,880.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$2,880.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,880.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

October 11, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.